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ABSTRACT

This technical assistance document provides guidelines for child assessment and eligibility determination for early intervention and early childhood special education programs in Oregon. An overview of the assessment process explains screening, eligibility evaluation, and assessment for the Individual Family Service Plan (IFSP). Legal requirements for determining eligibility under state law are then presented. Recommendations for assessment practices cover: examiner characteristics, gathering multiple sources of information, parent involvement, testing efficiency and sequence, adapting standardized assessments, and informed clinical opinion. Recommendations for planning an assessment address selection of an assessment battery, location of the assessment, observations in natural settings, and cultural competence in assessment. Child factors (such as visual or hearing impairment) that influence assessment are identified. Guidelines for test administration address examiner qualifications and procedures for learning to administer a new test. Finally, components of the multidisciplinary team report are considered. Appendices include tables comparing screening instruments, lists of instruments for determining eligibility, and lists of instruments for IFSP assessment and progress documentation. Also appended are definitions, the Code of Fair Testing Practices in Education, samples of multidisciplinary team reports, and eight references. (DB)

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Evaluation of Young Children for Early Intervention and Early Childhood Special Education

November1992

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Introduction

The purpose of this technical assistance paper is to provide Oregon Early Intervention (EI) and Early Childhood Special Education (ECSE) personnel with recommended guidelines for child assessment and determining eligibility in EI and ECSE programs. This paper defines and provides an overview of the child assessment process, requirements for determining eligibility for EI and ECSE programs, and guidelines for best practice in evaluating infants and young children. The recommendations contained in this paper are based on specifications for eligibility found in the Oregon Administrative Rules (OAR) 581-15-950, and OAR 581-15-051.

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Overview of the Child Assessment Process

Before there can be any discussion of the child assessment process in Early Intervention (EI) and Early Childhood Special Education (ECSE) programs, it is helpful to first agree on terminology. Three distinct steps, or processes are discussed in this paper. The first step is **screening**, which is "a brief assessment procedure designed to identify children who should receive more intensive diagnosis or assessment" (Meisels & Provence, 1989). The second step is **eligibility evaluation**, which includes the procedures used by qualified personnel to determine a child's initial and continuing eligibility for EI or ECSE services and to describe performance in a variety of developmental areas. The final step is **Individual Family Service Plan (IFSP) assessment**, where ongoing procedures are used throughout the child's time in the EI or ECSE program to develop a comprehensive and individualized educational plan, and to document progress.

Child assessment is a carefully formulated process that attempts to address the critical factors associated with providing services to appropriate children. This process outlines three steps that are separate, but complementary. Each step is fundamental to the delivery of quality services to young children.

Step One: Screening

The screening process should be efficient and economical with minimal over-identification (over-screening) of noneligible children and no under identification (under screening) of potentially eligible children. Tools developed for screening need to be brief, easy to administer, and easy to interpret (e.g., pass, fail), thus keeping per child cost low. It is essential to use tools that were developed for screening and not tools developed for establishing a diagnosis or for developing an IFSP. Instruments developed for these latter purposes provide in-depth information on children's behavioral repertoire and are costly to administer and interpret. Appendix I contains a list of screening instruments. This list is not exhaustive, but provides a sampling of reliable screening instruments that are available. EI and ECSE should honor all referrals made to their program, regardless of the screening procedure used for making the referral.

Step Two: Eligibility Evaluation

Procedures or instruments selected should yield results that permit determining if the child meets state criteria for eligibility for EI or ECSE. This requires more comprehensive and detailed information on the infant's or child's behavioral repertoire (i.e., what he or she can and cannot do). Instruments and procedures appropriate for screening are not appropriate for determining eligibility. In general, developmentally-based, norm-referenced instruments administered by trained examiners provide the type of outcomes necessary for establishing eligibility. Depending on the local process for determining eligibility, long term-goals may be developed at this step. Appendix II contains a list of evaluation instruments.

Step Three: IFSP Assessment

Program assessment follows if the child has been determined eligible for EI or ECSE services. For this step, different assessment procedures or instruments are necessary. Rather than yielding outcomes that permit comparison with norms and/or for establishing a diagnosis or eligibility, the outcomes should be program relevant for developing IFSP's. The assessment information should be directly applicable to the development of long and short-term objectives that constitute the child's IFSP. Appendix III contains a list of assessments used for developing short term objectives and for ongoing program development.

Table 1 presents a review of the three types of assessment involved in obtaining and delivering services, their purpose, possible examiners who are qualified to conduct the assessment, and the desired outcomes. Screening, eligibility evaluation, and IFSP assessment are separate processes that require different tools and procedures. Understanding this is fundamental to interpretation of the recommendations contained in these guidelines.

Table 1

Child Assessment Step	Purpose	Possible Examiners	Outcomes
One	Screening	Paraprofessional, and/or Professional	Pass (refer to other services, if appropriate) Fail (refer for eligibility evaluation) Questionable (refer for eligibility evaluation)
Two	Determine Eligibility	Professional Examiner	Ineligible (refer for follow up) Eligible (refer for services and develop long-term goals)
Three	IFSP Assessment (Program Assessment)	Professional, Paraprofessional, and Parent Team	Determine short-term objectives and document progress

Legal Requirements for Determining Eligibility

Overview of the Procedures for Establishing Eligibility

(1) Where concern about a child's development is indicated, the child and family are referred to the local designated Referral and Evaluation agency for intake and screening. Referral sources generally include physicians, public health nurses, social/welfare workers, child development specialists, public school personnel, mental health program personnel, preschool programs, day care programs, and parents. Following screening, a decision will be made by the multidisciplinary team (MDT) regarding the need for a formal evaluation of the child to determine eligibility. Children who fail the screening receive a complete evaluation, based on referral concerns and screening results. The particular MDT for a child should be identified by the designated Referral and Evaluation Agency in each county.

(2) After the decision is made to conduct an eligibility evaluation the designated Referral and Evaluation Agency is responsible to make sure that the appropriate evaluations are completed. The child must be evaluated in all areas of suspected disability (34 CFR 300.531). Following the evaluations, a written report (MDT report) must be developed explaining the results of the formal evaluation, including a review of previous testing, medical information, parent reports and information, and other evaluative information as necessary to determine eligibility and the need for services. The MDT report must indicate whether or not the child meets **eligibility** criteria and whether or not a **need** exists for early intervention or early childhood special education. All appropriate due process forms must be completed. These forms are included in the Department of Education technical assistance paper, Special Education Forms Volumes 1 and 2.

Trained personnel on the MDT administer approved norm-referenced instruments that meet the following criteria:

a) Tests are comprehensive including items in the areas of cognitive development, receptive and expressive language, gross motor development, fine motor development, social and self-help skills;
b) Tests are developmentally sequenced (items are arranged sequentially from easy to more difficult);
c) Tests are appropriate for either birth-to-two year olds or three-to-five year olds, or both age groups;
d) Tests have adequate normative (standardization) data (see Appendix IV for description);
e) Tests have adequate reliability and validity data (see Appendix IV for description);
f) Tests have outcomes that are interpretable for determining eligibility.

Evaluation for eligibility should be considered an ongoing, interactive process throughout the intervention period. It is recommended that services, the level of services, or the need for continuation of services be reviewed at least once within the first year of the individual family service plan (IFSP) even though the law (ORS 343.521) indicates an annual IFSP review. Due to the changes occurring in young children, a mid-year review may indicate significant improvements and a redetermination of services and placement may be necessary.

Rules and Guidelines (OAR 581-15-950):

(1) The designated referral and evaluation agency established in each county shall accept referrals and ensure that evaluations are conducted in compliance with federal and state regulations.

(2) Evaluations shall be conducted and shall:

(a) **Be administered by personnel trained in the use of the evaluation instruments;**

All individuals administering evaluations must be trained in evaluation and the use of evaluation instruments. Individuals administering evaluations for determining eligibility for the noncategorical developmental delay include supervisors, specialists, and related services personnel as defined in OAR 581-15-1100. Each must be trained in the administration of the particular tests being used. Personnel administering the eligibility evaluation for the IDEA categorical areas must be trained in the particular area being evaluated and be trained in the administration of the particular tests being used. For example, a speech/language pathologist must conduct the evaluation to determine eligibility for the speech/language area; a teacher, psychologist, or behavior consultant trained in the area of seriously emotionally disturbed must conduct the evaluation to determine eligibility for the seriously emotionally disturbed category; an audiologist must conduct the evaluation to determine eligibility for the hearing impaired category; an occupational or physical therapist must conduct the eligibility evaluation for the orthopedic impairment category.

(b) **Be conducted by a minimum of two trained personnel from different disciplines one of which is trained in the area of the suspected disability;**

*To determine eligibility in **any area,** at least two trained personnel from **different** disciplines must be involved. Different disciplines include, but are not limited to, teachers/specialists, speech/language pathologists, social workers, behavior consultants, audiologists, psychologists, physical therapists, and occupational therapists. For example:*

- *when only one area of disability is suspected, a person trained in that area should evaluate the child in that area and a teacher/specialist or psychologist should assess the child's overall development; or*
- *when determining eligibility for the mental retardation category, a psychologist should complete the eligibility evaluation and be accompanied by a physical therapist or occupational therapist if an orthopedic impairment is suspected; or*
- *when determining eligibility for the noncategorical developmental delay, a teacher/specialist trained in early childhood special education should complete the eligibility evaluation in conjunction with a behavior consultant or psychologist if seriously emotionally disturbed is suspected.*

(c) **Be administered in the child's native language or mode of communication, unless it is clearly not feasible to do so;**
It is imperative to document that all evaluations are conducted in a manner which will give a child the best opportunity to demonstrate abilities. Prior to any evaluation, the child's dominant language should be determined. The evaluators' efforts to ensure that the child's language and communication mode have been considered must be documented. Qualified examiners, fluent in the child's language, or interpreters, must be used to assist in the evaluation when the evaluator does not have fluency in the child's language.

(d) **Use evaluation instruments and procedures that are not racially or culturally discriminatory;**
Evaluation instruments must be carefully selected to prevent identification based on environmental, economic disadvantage or cultural issues. The evaluation instruments used should include norms of the racial group of the child being tested.

(e) **Use a minimum of two validated evaluation instruments, one of which shall be standardized;**
When conducting evaluations, all instruments must be validated and at least one must be standardized. The administration manuals for all evaluation instruments should indicate whether the instrument is validated and standardized. It is recommended that two instruments be used for ***each area*** *of suspected disability or delay in order to get a more complete picture of the child and according to federal and state law (34 CFR 300.532, 34 CFR 303.323, and OAR 581-21-030 which indicate that no single procedure can be used as the sole criterion). For example, when evaluating to determine eligibility for the noncategorical developmental delay, if a child is tested using the Battelle Developmental Inventory and is found to be below 1.5 standard deviations on the expressive language subtest and the gross motor development subtest, and the Preschool Language Sample is given as the second test, the evaluators should also complete the Peabody Motor Skills Test (or another motor test) as a second test for the motor area. Or, when evaluating a child to determine eligibility for seriously emotionally disturbed and speech/language, two tests for each area must be completed. These could be the Louisville Behavior Checklist and the Test of Early Social-Emotional Development for the seriously emotionally disturbed area and the Test for Early Language Development and the Test of Auditory Comprehension of Language Revised for the speech/language area. Evaluation instruments should be selected carefully to use with individual children depending on the child and the suspected area of disability or delay. Evaluators should not use the same evaluation instruments with every child. Also, the use of two intelligence (IQ) tests for one child should be avoided. In addition, evaluators should not use subtests to determine eligibility unless each subtest of the evaluation instrument has been individually standardized and the instructions indicate that subtest scores can be used independently of one another and can "stand alone." Nonstandardized tests should only be used to help substantiate the standardized test scores, or when standardized instruments can not be used because of the child's functioning level. In the latter case, the MDT report must document why standardized instruments were not used.*

(f) **Include a minimum of one observation of the child in his or her natural setting, if possible, with permission of the parent;**
To help substantiate the evaluation information, at least one observation must be completed. An observation should be at least 20 minutes in length and should occur in the child's natural setting, if possible. The "natural setting" is defined as the environment where the child spends 50 percent or more of his or her [active] day (OAR 581-15-900). Permission should be obtained prior to conducting an observation. Permission should be obtained as a part of the consent for initial evaluation.

(g) **Include a review of previous testing and medical information, parent reports and information; and**
All previous testing, medical information, and parent reports and information must be reviewed by the evaluators prior to the administration of any evaluation instruments and be considered when interpreting test results and information obtained through other methods. A summary of this information must be included in the MDT report.

(h) **Include other evaluation information as necessary to determine eligibility for early intervention or early childhood special education.**
Other evaluative information such as language samples, behavior rating scales, and teacher reports must be reviewed by the evaluators prior to or in conjunction with the administration of any evaluation instruments. This information, when collected, must be considered when interpreting test results and information obtained through other methods and used in the eligibility determination. A summary of this information must be included in the MDT report.

(3) Determination of eligibility shall occur within a "reasonable period of time" from the date parents sign the consent for evaluation. The Department of Education interprets "reasonable" as 45 days.

(4) A child shall be eligible for early intervention services:
- (a) From birth through 18 months of age when there is documentation from a physician licensed by a state board of medical examiners that the child has an identified genetic, neurological, muscular, or medical condition that will result in a developmental delay if not provided early intervention services; or
- (b) From birth through two years of age when there is documentation that the child's developmental age is:
  - (A) 56 to 75 percent of the child's chronological age in three or more of the following skill areas:
    - (i) cognitive development
    - (ii) receptive language
    - (iii) expressive language
    - (iv) gross motor development
    - (v) fine motor development
    - (vi) social, emotional, or behavioral development
    - (vii) self-help skills, or
  - (B) 40 to 55 percent of the child's chronological age in two of the skill areas in Subsection (4)(b)(A) of this rule; or

(C) Less than 40 percent of the child's chronological age in one of the skill areas in Subsection (4)(b)(A) of this rule; and

(c) The need for early intervention services is demonstrated by the evaluation results, observations, medical reports, and parent information.

(5) A child shall be eligible for early childhood special education when he or she is three years of age to eligibility for entry into kindergarten and;

(a) Experiences a developmental delay of 1.5 standard deviations or more below the mean in two or more of the skill areas listed in Subsection (4)(b)(i) of this rule; or

(b) Meets the criteria for one of the disabling conditions listed in OAR 581-15-051 *(added for clarification):*

Visually impaired	Seriously emotionally impaired
Hearing impaired	Mentally retarded
Speech/Language impaired	Autism
Orthopedically impaired	Deaf/Blind
Specific learning disability	Other health impaired; and

(c) The need for early childhood special education is demonstrated by the evaluation results, observations, medical reports, and parent information.

(6) Following completion of the evaluation, the designated referral and evaluation agency shall convene the MDT who shall:

(a) Review all evaluation data for the purposes of determining eligibility of the child for early intervention or early childhood special education services and the need to receive such services;

(b) Prepare a written report signed by the team members documenting the child's eligibility for early intervention or early childhood special education; and

(c) Forward a copy of the eligibility report to the contractor.

(7) Each contractor, subcontractor, or the designated referral and evaluation agency shall review the eligibility report with the child's parents prior to or during the initial IFSP meeting.

(8) The contractor shall notify the child's resident school district upon determination of eligibility for early intervention or early childhood special education (after obtaining parent permission for release of information).

(9) The contractor is responsible for ensuring that eligibility for services is based upon the results of evaluation information and that no child is deemed eligible without proper evaluation.

Assessment Practices

Obtaining valid and reliable information when assessing infants and young children is challenging and requires experience, planning, and creativity on the part of the examiner. Young children are often unable to sit for any great length of time and their language skills may not be developed to the point where they can respond to an examiner's question-and-answer format. In addition, young children's behavioral responses will most likely vary depending on their mood and physical state, the time of day, where the assessment is administered, and whether or not the examiner is familiar to the child.

Examiner Characteristics

Competent examiners of young children have experience in testing infants and young children and are knowledgeable about normal child development. Competence is demonstrated through:

- The ability to make the child feel comfortable by using language that is understandable to the child, such as short sentences and simple vocabulary;
- The ability to "follow the child's cue" by allowing the child to initiate contact with the examiner. Before the examiner begins testing, he/she will offer interesting toys or objects to the child to provide the child with time to adjust to a new situation;
- The ability to understand and respect the child's personal space by initially interacting from a distance. This is especially true for children whose stranger anxiety is high;
- The ability to maintain the child's attention, present test items, and record observations of behavior and responses, all in a relaxed, unhurried manner;
- The ability to be flexible and ready to change the assessment format when the child demonstrates normal preschool characteristics such as distractibility, fatigue, restlessness, shyness, or dependency; and
- The ability to establish rapport and communication with the parents. In addition, a good examiner will observe the parent's interaction style with their child and be able to take cues about what to do with the child.

Gathering Multiple Sources of Information

Gathering multiple sources of information on a child when determining eligibility is not only a good idea, both state rules and federal regulations mandate this practice. As discussed previously, standardized assessments may be difficult to administer to young children. A child's fluctuating performance or poor performance may be attributed to a variety of factors that a standardized assessment is unable to determine. Meisels and Provence (1989) state that "research has shown that no single factor is always present or always absent when high levels of socio-emotional and intellectual deficits are found" (pg. 23). A child's health and developmental outcomes are influenced by both biological and environmental factors and no single instrument or procedure can be sensitive enough to explain the complex nature of a child's development.

MDT's can gather reliable information on a child with advance planning. As a child may spend his or her day in a variety of settings and interact with several adults, team members should expect to collect information from multiple sources.

Information should be gathered from a variety of locations, as appropriate and with parent permission:

- Home
- Preschool, day care, or center-based program
- Other programs that may have impact on child and family

Information should be gathered from a variety of sources that are appropriate for each individual child:

- Parents
- Teachers
- Day care providers
- Therapists
- Health professionals

Information that must be considered when determining eligibility:

- Standardized norm-referenced tests;
- Observations in the natural setting;
- Review of health/medical records;
- Criterion-referenced tests (to supplement norm-referenced tests);
- Parent information, records of developmental milestones;
- Review of previous testing and records.

Approaches to gathering information:

- Direct testing
- Structured observation in several environments
- Interviews
- Parent checklists

Parent Involvement

Today, EI and ECSE personnel recognize the important role parents and families play in the development of their children. Parents **are** the major source of information regarding their child. Parents are also seen as the primary teacher of their child and the ones who best know the child. When families are involved in the assessment process, professionals not only gain valuable information about the child not learned from standardized assessments, they are also providing an opportunity to establish a relationship and partnership with families. Meisels and Provence (1989) have developed the following questions for EI and ECSE programs to consider regarding parent involvement in the assessment process.

1. What is the purpose of the assessment and what outcomes are to be achieved?

2. Will the assessment address the questions and concerns of the parents?

3. Are the parents involved in determining the nature of the assessment process, the areas to be assessed, and the methodology to be used, as well as the extent of their participation?

4. Will the assessment consider the child's developmental and adaptive functioning within the context of the family unit and parent-child interaction?

5. Does the climate of the assessment process encourage optimal comfort and sharing by family members and by professionals?

6. Are assessment findings presented in a jargon-free, integrated manner that promotes understanding and that emphasizes the child's strengths as well as vulnerabilities?

7. Are the parents involved in developing the IFSP and in determining the future course of action?

8. Are issues of cultural diversity included sensitively in the assessment process?

These questions provide EI and ECSE programs the opportunity to clarify and develop procedures for collecting information, the roles for families and professionals, and the expectations for all participants.

Testing Efficiency and Sequence

Examiners of young children often face a serious dilemma: a limited amount of time to obtain needed information and a child whom most often isn't concerned with timelines. In most testing situations, examiners do not have the luxury of unlimited time or days to evaluate a child. In a short period of time, the examiner

must establish rapport with the child, maintain his or her interest, and observe and record requested behaviors. Even though examiners must deal with time constraints, Ulrey (cited in Danielson, et al, 1988) has suggested guidelines for individuals to maximize the quality of their time when testing young children.

1. Know the test so well that the transition between test items are smooth and the child does not have a chance to get bored.

2. Be ready to present the next test item to the child just as soon as he or she finishes with the first task.

3. Take time to visit or interview the parents before the actual child assessment. The child can use this time to adjust to the stranger and new situation.

4. As the child becomes more comfortable with the examiner's presence, the examiner becomes more active offering the child an interesting toy or object. The examiner can then transition into a more formal testing situation.

5. Alternate easy items with more difficult items.

6. Administer interesting objects and/or non-language items first.

7. Repeat failed items at a later time if possible.

8. Reassure the parent as a ceiling is reached.

9. Do not push for a response if the child refuses to respond to an item or direction (children will let the examiner know when they are bored or do not know something. Insisting on a response frustrates both child and examiner).

One final note: If an examiner is unable to complete an evaluation of a child for whatever reason, he or she **has not** failed. It is appropriate to say that the testing situation ended before the evaluation was completed. If a child is too tired or too distracted, the information gathered is not a reliable measure of the child's true abilities. It is inappropriate for an examiner to try to infer information about a child from incomplete testing results. The examiner should schedule another time to evaluate the child.

Adapting Standardized Tests

There are few good standardized tests available for evaluating infants and young children. Given the limited number of available tests, examiners may find it necessary to adapt tests to assess a child's strengths and needs. When it is determined necessary to adapt a standardized test, **the results must be interpreted with caution**. Once a standardized test has been adapted, the norms for that test can no longer be used and the scores should **not** be reported. A standardized test

that has been adapted may provide useful information about what the child can and cannot do in relation to developmental standards, but the scores are not accurate or useful. In the instances where tests have been adapted, these adaptations should be noted in any written reports.

There are two conditions when examiners may find adapting tests necessary (Danielson, et al, 1988):

1. when a child cannot achieve even a minimal score at the lower end of a test that is appropriate to the child's age, or

2. when a child's handicapping condition makes standard use of a scale impossible.

Tests should be adapted when the resulting information can provide valuable insight to the MDT. If tests must be adapted to determine a child eligible for EI or ECSE services, the MDT **must assure** that all supporting evidence has been gathered to document the child's disability and need for EI or ECSE services. At least one of the tests administered to the child should be standardized.

Informed Clinical Opinion

The use of informed clinical opinion by MDT members is necessary but controversial in EI and ECSE programs. Informed clinical opinion uses qualitative and quantitative information to assist in forming a determination regarding the potential need for EI or ECSE services. Eligibility for EI and ECSE services, as outlined in OAR 581-15-950, includes requirements for standardized assessment, an observation in the natural setting, review of previous testing, medical information, parent reports, and other evaluation information necessary to determine eligibility. Not only are the scores from standardized assessments required for eligibility determination, so are the reviews of the above stated additional requirements. **Informed clinical opinion does not preclude the use of standardized assessments to determine eligibility**. The review of all the above information is necessary for MDT members to effectively become informed about the child's developmental needs and eligibility status. The conclusions reached by the MDT should be documented, in writing, and become a part of the MDT report.

Elements of informed clinical opinion may include:

- clinical interviews with parents;
- evaluations of the child at play;
- observation of parent-child interaction;
- information from teachers or child care providers; and
- neurodevelopmental or other physical examinations.

All of the information obtained must be reviewed and integrated to develop a total picture of the child.

Planning An Assessment

Selecting an Assessment Battery

The instruments and procedures selected for each child should be individualized to the referral questions, demonstrate technical adequacy, and be appropriate to the unique characteristics of the child and family. Table 2 (Neisworth & Bagnato, 1986) lists characteristics of good assessment batteries.

Table 2

ASSESSMENT OF YOUNG CHILDREN SHOULD BE:

MULTIMEASURE	battery consists of several types of assessment techniques (i.e., observation, parent interview, structured eliciting tasks, etc.);
MULTISOURCE	battery contains input from parents and several team members;
MULTIDOMAIN	battery allows for analysis of several interrelated developmental and behavioral processes; and
MULTIPURPOSE	as much as possible, battery simultaneously services as a guide to individual intervention and program planning and evaluation.

Where Should Assessments Take Place?

The setting for evaluation of infants and young children is an important step in the assessment planning process. Evaluating a child in an informal setting, such as home or day care, provides an opportunity for the child and family to be relaxed in a comfortable and familiar setting. (While this can be an advantage in many cases, some home environments may not be conducive to testing.) Unfortunately, most EI and ECSE programs cannot afford the luxury of evaluating all children in their home environments.

More formal settings, such as specialty clinics, pediatricians' offices, or schools may be intimidating to children and families, but they may also have some built in advantages. First, a child needing a comprehensive evaluation in many areas of development may easily be evaluated when all team members are in a single location. Second, some specialized assessments require settings with few distractions, such as audiometric examinations. Third, assessing a child in a formal setting controls distracting elements such as siblings, barking dogs, and ringing phones.

There are advantages and disadvantages to any testing situation, which points to the need for multiple assessments and observations of the child in his or her natural setting. Illness, fatigue, fear, anxiety, excitement, or upset from any source can influence an infant's or young child's behavior during an assessment (Meisels & Provence, 1989). The process for determining eligibility for any child should not be based on a one-time evaluation.

Observations in Natural Settings

While gathering information from standardized tests is mandated for establishing eligibility for services, a child's test behavior may not be a typical representation of their behavior in other settings (Bracken, 1991). Observations of young children in their natural settings are used to compliment the use of standardized tests. Observations provide valuable information about specific child behaviors and abilities that may or may not have been observed during the formal testing situation. Specifically, planned observations may confirm or dispute findings from formal assessment, help explain variable test performance, informally assess functional skills, and provide opportunities to observe the child's interactions with peers and adults in familiar surroundings.

Observations of a child in multiple environments would be ideal, but limited budgets, staff, and time make this a difficult, if not impossible task. For eligibility purposes, OAR 581-15-950 mandates that EI and ECSE programs make at least one observation of a child in his/her natural environment. As defined previously, a child's natural environment is one where the child spends more than 50% of their day. A child's nonevaluation behavior may be observed in a preschool classroom during structured and nonstructured activities, in the home, a day care setting, at a baby-sitter's home, or any other representative environment where the child spends a major portion of their active day. Such observations should be for no less than 20 minutes. Parent permission must be obtained before observations outside of the formal testing situation are undertaken.

Individuals planning observations in the natural environment should determine beforehand **what** they want to observe and **how** they will obtain the information. Observers have generally collected their data from formal assessments and are looking for additional information to supplement their objective data. Observation periods are usually short periods of time so the observer must have some idea what he or she is looking for. The following behaviors (Bracken, 1991) are a partial listing of potential behaviors that may be observed in a variety of settings.

- *Speech and Language* - observation of a child's language skills in a natural setting can provide information about the child's cognitive abilities and level of social and emotional development. It is important to observe the child's communicative intent, both verbally and nonverbally (with peers, parents, caregivers, teachers, etc.), and the ability to follow directions.

- *Fine and Gross Motor Skills* - a child may score poorly on motor scales due to shyness, fear of failure, or an inability to comprehend the verbal directions for the task. In addition, a child with a lack of educational experience may not perform well on formal drawing, coloring, or cutting

tasks, but may do very well with buttoning, zipping and manipulating small objects. A child observed outside the formal testing situation may demonstrate abilities not observed during a standardized test.

- *Social Interactions* - observing a child in their natural setting provides valuable information about the child's ability to cope and interact with peers and caregivers. Caution must be taken before any direct inferences about a child's behavior are made from any one observation period. Any child with referral concerns in social and emotional development must be observed in at least two different settings.

Other information may be also be sought during an observation in a child's natural setting. It is helpful for observers to have some idea what they are looking for and develop a plan for obtaining the information. The following strategies are suggested methods for collecting observational information on children.

- *Narrative Descriptions* - an informal collection of descriptions about a child that are gathered over time by teachers or other caregivers. Observations of the child are not necessarily structured or planned, but the observer will intermittently record relevant events after they happen.

- *Running Record* - a continuous record of a child's behavior over an extended period of time. This is a time-consuming process that requires detailed notes and regularly scheduled observations.

- *Checklist or Rating Form* - used to gather information on development of specific skill areas.

Cultural Competence in Assessment

Many EI and ECSE programs in Oregon are serving families from a variety of linguistic and cultural backgrounds. These families can have a major impact on programs and service delivery. In particular, the issues around screening and assessment practices are extremely important for all service providers to consider. As discussed previously, the availability of standardized instruments that meet requirements for determining eligibility is extremely limited. Of those instruments that do meet requirements, most are not available in a variety of languages. In addition, most of the instruments available have not included a wide range of cultures in their standardization samples. These instrument limitations may lead to biased test results for an unprepared MDT.

Individuals working in EI and ECSE programs must become proficient in working with families from a variety of backgrounds. They must be prepared to learn and be open to variations within the same cultural group. Cultural variables (Anderson & Fenichel 1989) cross all cultures and include:

> How people feel about, manifest and treat health, illness, and physical, mental, and emotional disabilities; the group of people in one's life who are considered to be family members and the relationships these people have to

> each other; childrearing techniques; and language and the different ways in which people communicate. (p. 7)

Anderson and Fenichel (1989) go on to define cultural sensitivity as it applies to EI and ECSE programs:

> Cultural sensitivity implies, rather, knowledge that cultural differences as well as similarities exist, along with a refusal to assign values such as better or worse, more or less intelligent, right or wrong to cultural differences; they are simply differences. (p. 8)

EI and ECSE providers can become aware of the cultural groups that live in their communities and learn some of the general characteristics of those cultures. This knowledge will provide a *starting point* for the providers and families as they establish a working relationship. EI and ECSE providers are then aware of some of the possibilities that they may encounter with a family, but they must then individualize the information to each family. *Assumptions based on characteristics of a particular cultural group cannot be generalized across that entire group of people.*

EI and ECSE service providers need to learn the limitations of different assessments to avoid the misinterpretation of assessment results. In other words, programs must become culturally competent to deal with individual families in a variety of situations. Cultural competence has been defined by Roberts (1990) as "a program's ability to honor and respect those beliefs, interpersonal styles, attitudes, and behaviors both of families who are clients and the multicultural staff who are providing services" (p.1).

There are several ways for EI and ECSE providers to increase their cultural competence in dealing with families from diverse backgrounds. First, increase awareness by reading prepared materials on the subject (see references) and attending workshops as they become available. Second, hire and learn from bilingual, multicultural staff. Much of the learning about different cultures happens "on the job," and it may be perfectly appropriate to ask families for clarification when issues arise. The following two examples of families from different cultures highlights how misunderstandings can occur through family interview and child assessment.

Example One: A two-year-old child of Asian American descent is referred by a concerned health professional to an Early Intervention program. The referral concern for this child is that he is not yet walking. The examiner has some basic information about Asian American culture, and wonders if the mother's practice of carrying her child may have delayed the onset of his ability to walk independently. Is this child really delayed and in need of service? It's not an easy yes or no answer. The examiner has some basic information, but must investigate further before any conclusions can be drawn. It is only after a relationship has been established with the family and appropriate assessments have been completed that the need for services can be determined.

Example Two: A Native American child is being evaluated for eligibility for ECSE services. The child avoids all direct eye contact with the examiner and appears to be very quiet and withdrawn. Does this child display some autistic tendencies or emotional problems? The examiner is aware that maintaining direct eye contact in many Native American cultures is a sign of disrespect. In addition, young children are often "seen and not heard." The examiner cannot assume anything about this child based on previous knowledge about Native American culture. The examiner must first get to know this family on an individual basis and provide appropriate assessments before any conclusions can be drawn.

EI and ECSE providers may be able to generalize some basic characteristics about diverse cultures, but must remember that all families function individually based on their own values and beliefs!

In *Cultural Competence in Screening and Assessment: Implications for Services to Young Children with Special Needs Ages Birth through Five* (1991), Anderson and Goldberg provide, in the following two pages, additional strategies and questions for providers to use when working with families from a variety of backgrounds.

Strategies for Professionals Working with Families from Various Cultural and/or Linguistic Groups

1. Individualize the screening and assessment process for parents as well as for children. Children and other family members may be at various levels of acculturation and may require similar or varying degrees of modifications, adaptations, or support, such as language interpretation.

2. Do a self-assessment of your own cultural background, experiences, values, and biases. Examine how they may impact your interactions with people from other cultural groups.

3. Begin the screening and assessment process at the point where the parents are. Find out their concerns, why they are coming to you, and what they hope you can provide.

4. Take the time to establish the trust needed to fully involve the family in the screening and assessment process.

5. Use bilingual and bicultural staff, or mediators and translators whenever needed. Try to maintain a consistency of providers to allow the family to establish ongoing communication.

6. Allow for flexibility of the process and procedures. You may need to meet with parents at their job site, or call them when they return home from their job. You may need to modify test items to ensure cultural competency.

7. Conduct observations and other procedures in environments familiar to the child. These may be at the home of their grandmother, outdoors, or at their parents' work site.

8. Provide assistance and be flexible in establishing meetings with parents. This might include providing for child care of siblings, transportation to a meeting site, or meeting the family in their home.

9. Participate in staff training on cultural competence skills in screening and assessment. Strive to achieve standards for professional competence.

10. Conduct ongoing discussions with practitioners, parents, policymakers, and members of the cultural communities you serve.

From *Cultural Competence in Screening and Assessment: Implications for Services to Young Children with Special Needs Ages Birth through Five* (p.22) by M. Anderson and P. Goldberg, 1991, Minneapolis, MN: PACER Center and NEC*TAS. Reprinted with permission.

Questions for Professionals to Ask When Conducting a Culturally Sensitive Screening and Assessment

1. With what cultural group was this screening or assessment tool normed? Is it the same culture as that of the child I am serving?
2. Have I examined this screening and assessment tool for cultural biases? Has it been reviewed by members of the cultural group being served?
3. If I have modified or adapted a standardized screening or assessment tool, have I received input on the changes to be certain it is culturally appropriate? If using a standardized tool, or one to which I have made changes, have I carefully scored and interpreted the results in consideration of cultural or linguistic variation? When interpreting and reporting screening and assessment results, have I made clear reference that the instrument was modified and how?
4. Have representatives from the cultural community met to create guidelines for culturally competent screening and assessment for children from that group? Has information about child-rearing practices and typical child development for children from that community been gathered and recorded for use by those serving the families?
5. What do I know about the child-rearing practices of this cultural group? How do these practices impact child development?
6. Am I aware of my own values and biases regarding child-rearing practices and the kind of information gathered in the screening and assessment process? Can I utilize nondiscriminatory and culturally competent skills and practices in my work with children and families?
7. Do I utilize parents and other family members in gathering information for the screening and assessment? Am I aware of the people with whom the child spends time, and the level of acculturation of these individuals?
8. Do I know where or how to find out about specific cultural or linguistic information that may be needed in order for me to be culturally competent in the screening and assessment process?
9. Do I have bilingual or bicultural skills, or do I have access to another person who can provide direct service or consultation? Do I know what skills are required of a quality interpreter or mediator?
10. Have I participated in training sessions on cultural competence in screening and assessment? Am I continuing to develop my knowledge base through additional formal training and by spending time with community members to learn the cultural attributes specific to the community and families I serve? Is there a network of peer and supervisory practitioners who are addressing these issues, and can I become a participating member?

From *Cultural Competence in Screening and Assessment: Implications for Services to Young Children with Special Needs Ages Birth through Five* (p.23) by M. Anderson and P. Goldberg, 1991, Minneapolis, MN: PACER Center and NEC*TAS. Reprinted with permission.

Child Factors that Influence Assessment

The unique needs of some children require extra time, planning, and knowledge of how to adapt the testing situation and materials. When the situation warrants, the examiner should attempt to adjust and optimize the child's assessment results. Consultation or team assessment with an appropriate therapist will greatly increase the chances of obtaining valid and reliable assessment results. Any modifications of a standardized assessment, however, **must** be documented in the MDT report. Special considerations for children with physical, visual, or hearing disabilities are discussed below.

Physical Disability

To effectively evaluate a child with a physical disability, the examiner must first be informed about the disability and the child's limitations. In addition, an occupational or physical therapist should be consulted before the child is evaluated. The parents of the child can provide invaluable information regarding the child's needs and abilities, communicative intent, and any equipment required for positioning. If the child uses adaptive equipment for positioning, it should be used during the evaluation. The parents may also provide interpretations for the child's gestures, facial expressions, or eye movements, when appropriate. In addition, the parents may know if the child fatigues easily, which will require shorter testing periods over several different days. The examiner may also need to allow extra time for the child's delayed response to an item. Observation the child is also an effective way of determining any special considerations needed for the testing situation. Observation may cue the examiner on the most effective positions for working with the child, how the child manipulates materials, and the types of assistance the child needs for positioning or mobility. Again, any adaptations in standardized tests should be noted and results reported with caution.

Visual Impairment

For the child with a visual impairment, a vision specialist should be consulted before the child is evaluated. The examiner must obtain information on the child's disability and the extent of the visual loss. The examiner must also determine, through parent interview and observation, the child's adaptive methods for learning and language comprehension abilities. The examiner can only provide verbal directions and cues if he or she is confident that the child understands the directions. In addition, the examiner should use a familiar environment to the child for the evaluation. If the child normally wears glasses, it is important for him or her to do so during the evaluation. The examiner should provide a set work area with good lighting and use large, brightly colored materials. As many distracting materials and sounds as possible should be removed from the testing area.

Hearing Impairment

For the child with a hearing impairment, a hearing specialist should be consulted before the child is evaluated. The examiner must obtain information on the nature and extent of the child's hearing loss. The child's parents can be very helpful for understanding the child's abilities and limitations. In addition, it is important to know how much functional hearing the child has. If the child signs, the examiner should sign or use an interpreter for the evaluation. If the child wears hearing aids, make sure they are functioning properly and worn during the evaluation. As much as possible, instruments should be selected that are nonverbal in nature. The examiner should sit across from the child, with the child's back to the window. It is important to have eye contact with the child to ensure he or she understands the directions. A child's nodding and smiling response may be an indication of learned socially appropriate behavior rather than a true understanding of the situation. Lighting should be good and materials should be bright, textured, and interesting to look at. In addition, the testing environment should be quiet and free from visual distractions.

Guidelines for Test Administration

Qualified Examiners

There are two basic rules that guide test administration:

(a) Tests administered for decision-making purposes must be validated for that purpose.
(b) Individuals administering tests must be competent to do so.

Extensive and comprehensive training is needed by individuals involved in the EI and ECSE assessment process. Competence in test administration is usually defined in terms of general training (education), and in terms of training and/or practice specific to the given test. The Standards for Educational and Psychological Testing (cited in Danielson et al. 1988) provide several key points for professionals involved in test administration:

(a) Any individual involved in test administration should be "properly instructed in the appropriate test administration procedures" and should "understand the importance of adhering to the directions for administration that are provided by the test developer" (Standard 8.1, p. 52). In addition, test users should be "properly instructed in the appropriate methods for interpreting test scores" (Standard 8.2, p. 52).
(b) Individuals involved in test administration are responsible for monitoring their own skill and making sure that they have "training and experience necessary to handle this responsibility. ...Any special qualifications for test administration or interpretation noted in the manual should be met" (Standard 6.6, p.42).
(c) When assessing individuals "whose special characteristics--ages, handicapping conditions, or linguistic, generational, or cultural backgrounds--are outside the range of their academic training or supervised experience," test users "should seek consultation regarding test selection, necessary modifications of testing procedures, and score interpretation from a professional who has had relevant experience" (Standard 6.10, p. 43).

Procedures for Learning to Administer a New Test

The field of EI and ECSE is experiencing constant change for those professionals working with young children and their families. When new tests become available on the market, professionals should follow the suggested sequence of procedures found in Danielson et al. (1988, p. 15) for learning to administer a new test, or relearning a currently used instrument.

(a) Thoroughly read the manual covering administration and technical information.
(b) Read and carefully practice the instructions for administration of each part of the test.

(c)' Administer the test, if possible, to a professional peer who is learning or has already learned the same test so that points of confusion or concern can be discussed.

(d) Practice administering the complete test until the administration of it is comfortable.

(e) Have another professional observe and critique the test administration if possible.

(f) Periodically reread the entire manual and all administration directions to avoid learning bad habits or incorrect procedures. (It is also a good idea to establish procedures for peer observation and review so that professionals can be sure that standard procedures are being followed.)

Multidisciplinary Team Report

The MDT report is a compilation of the multiple sources of information that have been gathered on a child. The report is a means of communicating the results of an evaluation to the parents of the child being evaluated and to other professionals. It also provides baseline information for the IFSP team of the child's needs and abilities, and is a starting point for developing long term goals for the IFSP. Reports should be written in such a way that information is conveyed without using technical terms or jargon, so that the content is easily understood by parents and other professionals.

A well-written MDT report has the following characteristics:

- The report describes the child as a unique individual. The focus of the report is on needs and abilities of the child and not on test scores.
- The report addresses the original referral concerns and answers the questions of both parents and professionals.
- The report synthesizes information obtained from all sources: Parent input, observations, formal testing, medical reports, and any other pertinent information.
- The report makes specific recommendations regarding the needs of the child that will be useful in writing the IFSP.

The Department of Education does not require a standard format for reports, but requests that certain information be contained in all MDT reports. The following page is a checklist of items that should be included when teams are writing MDT reports. Two examples of MDT reports are included in Appendix VI. The examples are included as suggestions only and are not required by the Department.

Multidisciplinary Team Report Checklist
Early Intervention/Early Childhood Special Education Programs

The following information should be included in all Multidisciplinary Team (MDT) reports for Early Intervention and Early Childhood Special Education reports.

- ❑ **Child Information:**
  -Name, DOB, Age
  -Resident District
  -Current Program, Provider Name and Phone
  -Parent Address and Phone
  -Referral Coordinator and Phone

- ❑ **Reason for Referral and Suspected Disability**
  -Initial Referral
  -3 Year Evaluation
  -Evaluation of Current Program
  -Other (explain)

- ❑ **Summary of Evaluations, Parent Input, and Present Performance**
  -Age at which concerns were first noted by parent and/or program
  -Developmental, medical, and other significant background from parent and other sources. Information should include, as appropriate, pertinent information from any previous preschool or daycare experiences
  -Summary of Evaluation Results: *Include functional performance*
  Cognitive
  Receptive Language
  Expressive Language
  Gross Motor
  Fine Motor
  Self-Help
  Social

- ❑ **Documentation of disability under OAR 581-15-950 or OAR 581-15-051**

- ❑ **Documentation of the child's need for EI or ECSE services through review of evaluation results, observations, medical reports, and parent information.**

- ❑ **Information regarding learning/teaching styles that may require program modifications.**

- ❑ **Name, Title, and reports from individual MDT members.**

- ❑ **Dissenting reports included from MDT members (if appropriate).**

Appendix I

Screening Instruments

The following table of screening instruments are recommended for use in Early Intervention and Early Childhood Special Education programs.

Selected Screening Instruments for Children Birth to 5 Years of Age

INSTRUMENT	AGE RANGE	ADM. TIME	SCORES	TYPE	TECHNICAL DATA (Validity/Reliability)	COMMENTS
Battelle Developmental Inventory Screening Test (BDIST) 1984 DLM Teaching Resources One DLM Park Allen, Texas 75002 (Spanish version available)	6 months to 8 years	30 minutes	Outcomes: Age equivalent scores and pass/fail scores	Norm Referenced[a]	Not available for review, can be obtained from publisher	Includes seven subtests: personal-social, adaptive, gross motor, fine motor, receptive language, expressive language, and cognitive. Items use a combination of interview, direct elicitation, and observation. Over-referrals may occur when entire score is used.
Denver-II 1990 Denver Developmental Materials, P.O. Box 6919 Denver, CO 80206 (Also available in Spanish)	Birth to 6 years	15 to 20 minutes	Outcomes: Pass/Fail	Norm Referenced n=2000 Stratified by: age, race, SES, urban vs rural	Information on validity not provided in review. High reliability[b] reported.	Screens four domains: personal-social, fine motor-adaptive, language, and gross motor. A brief behavior scale has also been included as well as mutiple measurement methods.
Developmental Indicators for the Assessment of Learning-Revised (DIAL-R) 1990 Childcraft Education Corporation 20 Kilmer Rd. Edison, NJ 08818	2 to 6 years	25 mintues	Outcomes: Standard Deviations and Percentiles	Norm Referenced (currently under revision)	Correlations with Stanford-Binet: Motor= .28; Concepts= .50; Language= .33; Overall= .40 TR= .87	Team-based screens motor, language, and concepts. Parent information is also collected. The communication/language section tends to under-refer children in need of further evaluation.
Developmental Profile II (DP-II)1986 Western Psychological Services Publishers & Distributors 12031 Wilshire Blvd. Los Angeles, CA 90025	Birth to 9 years	20 to 30 minutes	Outcomes: Age equivalent, pass-fail, and months-differential scores	Norm Referenced n=3,000 Stratified by: race, SES	Validity information provided in manual. TR= .71 IR= .50 - .92	Information obtained through parent interview or direct observation. Measures gross and fine motor skills, self-help, cognitive-academic and expressie-receptive language skills.

[a]Reliability: *(TR)= Test-Retest (SH)= Split-Half (IR)=Inter-Rater

[b]Norm Referenced: Percentile, Percentile Rank, Age Equivalent, Standard Score, Developmental "Age", Quotient (Developmental, Language, etc)

[c]Criterion-Referenced: Mastery levels, Raw score

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Selected Screening Instruments for Children Birth to 5 Years of Age

INSTRUMENT	AGE RANGE	ADM. TIME	SCORES	TYPE	TECHNICAL DATA (Validity/Reliability)	COMMENTS
Infant Monitoring System (IMS) 1989 Center on Human Development/EIP University of Oregon 901 E. 18th Eugene, OR 97403 (Also available in Spanish version)	4 to 36 months	10 to 15 minutes	Outcomes for each subtest: performance below 2nd SD results in referral	Norm Referenced	Available from authors in detail. Agreement with other measures .85. TR= .86 - .91.	Relies exclusively on parent report. The IMS is mailed to families at regular intervals: 4, 8, 12, 16, 20, 24, 30, and 36 months of age. Assesses communication, gross and fine motor, adapative, and personal-social skills.
Early Screening Inventory (ESI) 1983 Teachers College Press PO Box 1540 Hagerstown, MD 21740 (Also available in Spanish and Korean)	3 to 6 years	15 to 20 minutes	Outcomes: OK Rescreen Refer	Norm Referenced n=465 normal children ages 4.2 to 5.10. White low to low-mid SES urban families	Concurrent validity with the McCarthy Scales of Children's Ability= .73 IR= .91 TR= .91	Screens speech, language, cognition, perception, and gross and fine motor coordination. Parent questionnaire is also included. A Spanish version of the ESI is being standardized.
Miller Assessment for Preschoolers (MAP) 1982 The Psychological Corporation 555 Academic Court San Antonio, Texas 78204	2.9 to 5.8 years	20-30 minutes	Outcomes: Percentiles	Norm Referenced n=1,014 Stratified by: geographic region	Content validity TR= .81-.98	Screens sensory and motor abilities, cognition, and combined abilities, and use of a Supplemental Observation Sheet (time consuming).
AGS Screening Profiles (1990) American Guidance Services Publisher's Building Circle Pines, MN 55014-1796	2 to 6.11 years	15 to 30 minutes. for child. 10 to 15 minutes for quest-ionnaires	Outcomes: Screening index (1-6 rating); Standard Scores	Norm Referenced	Correlations of cognitive/language profile with K-ABC and Stanford-Binet range from .68 to .84. TR= .78 to .89. IR= .83 to .99	Measures development in multiple domains, including cognitive/language, motor, and self-help/social. Low cost screening designed to test large numbers of children. Includes parent/teacher questionnaires.

[a]Reliability: *(TR)= Test-Retest (SH)= Split-Half (IR)=Inter-Rater

[b]Norm Referenced: Percentile, Percentile Rank, Age Equivalent, Standard Score, Developmental "Age", Quotient (Developmental, Language, etc)

[c]Criterion-Referenced: Mastery levels, Raw score

Selected Screening Instruments for Children Birth to 5 Years of Age

INSTRUMENT	AGE RANGE	ADM. TIME	SCORES	TYPE	TECHNICAL DATA (Validity/Reliability)	COMMENTS
Minnesota Child Development Inventories (MCDI): Infant Development Inventory 1988 Early Child Development Inventory 1988 Preschool Development Inventory 1984 Behavior Science Systems, Inc. P.O. Box 1108 Minn, MN 55440	0-15 mo 1-3 yrs 3-6 yrs	20 to 30 minutes	Outcomes: Scores summarized graphically on MCDI Profile	Norm Referenced n=796 normal white children from sub-urban Minn. (Renorming underway)	Not available for review	Uses parent observations on 60-80 items (each inventory) in general development, gross and fine motor, expressive language, comprehensive-conceptual, situation comprehensive, self-help, and personal-social. Over-refers children not at risk. Depends on the parents ability to report accurately and to be able to read (time consuming).
Denver Developmental Screening Test Revised (DDST-R) 1981 Denver Developmental Materials PO Box 6919 Denver CO 80206 (Also available in Spanish)	2 weeks to 6 years	15 to 20 minutes	Outcomes: Pass/Fail	Norm Referenced n=1,036 Stratified by: normal child. 2 wks to 6.4 years in Denver.	Concurrent validity with Stanford-Binet, Cattell, and Bayley= .74 to .97. TR= .66 to .93	Screens four developmental areas: personal-social, fine motor-adaptive, language, and gross motor. Errs on the side of under-referrals. Questionable reliability for children under the age of two.
Minneapolis Preschool Screening Instrument (MPSI) 1980 Minn. Public Schools, Sp.Ed Division 254 S. Upton Ave Minn, MN 55405	3.7 to 5.4 years	15 minutes	Outcomes: Pass/Refer	Norm Referenced n=1,320 Stratified by: sex, age, and SES.	Concurrent validity with Stanford-Binet= .71 TR =.92	Screens cognitive, language, perceptual, and fine motor skills.
Early Language Milestone Scale 1987 Pro-Ed 8700 Shoal Creek Blvd Austin, TX 78758	0 to 36 months	1 to 3 minutes	Outcomes: Pass/Fail	Norm Referenced	Correlations with Stanford-Binet= .66, with ITPA= .55 No reliability reported	Technical data is weak. Designed to be used by physicians for quick global screening for early language. Screens auditory expression, auditory receptive, and visual.

[a]Reliability: *(TR)= Test-Retest (SH)= Split-Half (IR)=Inter-Rater
[b]Norm Referenced: Percentile, Percentile Rank, Age Equivalent, Standard Score, Developmental "Age", Quotient (Developmental, Language, etc)
[c]Criterion-Referenced: Mastery levels, Raw score

Selected Screening Instruments for Children Birth to 5 Years of Age

INSTRUMENT	AGE RANGE	ADM. TIME	SCORES	TYPE	TECHNICAL DATA (Validity/Reliability)	COMMENTS
Revised Developmental Screening Inventory (RDSI) 1980 Developmental Test Materials 17 Fireside Lane Latham, NY 12110	4 weeks to 36 months	15 to 20 minutes	Outcomes: Developmental Quotient	Norm Referenced n=125 infants from Albany, NY (Sample from original Gesell).	Not available.	Consists of selected items from the Revised Gesell. Items cover: Adaptive, gross motor, fine motor, language, and personal-social.

[a]Reliability: *(TR)= Test-Retest (SH)= Split-Half (IR)=Inter-Rater

[b]Norm Referenced: Percentile, Percentile Rank, Age Equivalent, Standard Score, Developmental *Age*, Quotient (Developmental, Language, etc)

[c]Criterion-Referenced: Mastery levels, Raw score

Appendix II

Instruments for Determining Eligibility

The following table of instruments for determining eligibility are recommended for use in Early Intervention and Early Childhood Special Education programs.

Selected Cognitive Instruments for Determining Eligibility for Children Birth to 5 Years of Age

INSTRUMENT	AGE RANGE	ADM. TIME	SCORES	TYPE	TECHNICAL DATA (Validity/Reliability)	COMMENTS
Bayley Scales of Infant Development 1969 The Psychological Corporation 555 Academic Court San Antonio, TX 78204	2 to 30 months	Mental: 25-30 minutes	Raw scores Index Scores (convert to normalized standard scores)	Norm Referenced n=1.262 nor. inf. & child. Stratified by: geo. area, urban vs rural, sex, race, & ed. of head of house	Correlation of .57 with the Stanford-Binet TR Mental: .61 to .93	Includes mental scales and motor scales. Parent is present during testing. Usually requires a psychologist to administer, or a specially trained professional (see also motor).
Kaufman Assessment Battery for Children (K-ABC) 1983 American Guidance Service Publisher's Building Circle Pines, MN 55014 (includes socioculutural norms for minority students)	2 1/2 to 12 years	35 to 90 minutes	Standard scores, percentile ranks, age and grade equivalents	Norm Referenced n=2,000 in 9 age groups. Stratified by: age, sex, geo. region, SES, race, comm. size. (1980)	Concurrent validity ranging from .60 to .79 on WISC-R,Stanford-Binet, and McCarthy Scales TR= .90 on mental processing composite	K-ABC scores four global areas: sequential processing, simulaneous processing, mental processing composite, and achievement. Includes attractive materials for preschools and sample unscored teaching items. Administration of K-ABC requires extensive training.
McCarthy Scales of Children's Abilities (MSCA) 1972 The Psychological Coorporation 555 Academic Court San Antonio, TX 78204	2.5 to 8.5 years	45 to 50 minutes	General cognitive index, scale indexes, percentile ranks, and mental age	Norm Referenced n=1,032 in 10 age groups Stratified by: age, sex race, geo., region, father occ., & urban vs rural. (1970)	Concurrent validity ranges from .81 with Stanford-Binet and from .62 to .71 with the Wechsler Preschool and Primary Scale of Intelligence (WPPSI) TR .90 on GCI and average of .81 for the five scale indexes.	MSCA providess a general level of intellectual functioning (GCI) and a profile of verbal ability, nonverbal ability, number aptitude, short term memory, and motor coordination. Materials are attractive to children and test is organized to maintain child's interest. Extra trials and examples are allowed on some of the subtests.

[a]Reliability: *(TR)= Test-Retest (SH)= Split-Half (IR)=Inter-Rater

[b]Norm Referenced: Percentile, Percentile Rank, Age Equivalent, Standard Score, Developmental *Age*, Quotient (Developmental, Language, etc)

[c]Criterion-Referenced: Mastery levels, Raw score

Selected Cognitive Instruments for Determining Eligibility for Children Birth to 5 Years of Age

INSTRUMENT	AGE RANGE	ADM. TIME	SCORES	TYPE	TECHNICAL DATA (Validity/Reliability)	COMMENTS
Stanford-Binet (Fourth Ed.) 1985 The Riverside Publishing Company 8420 Bryn Mawr Avenue Chicago, IL 60631	2 years to adult	60 to 90 minutes	Standard Scores called Standard Area Scores, IQ scores	Norm Referenced n=5,013 in 17 age groups n=460 for ages 5.0 to 5.11. Stratified by: geo. region, ethnic, age, sex & SES (1980)	Correlations obtained between the SB and the Bayley Scales .57; between the SB and K-ABC .82 to .89. Ages 2 to 5 .74 to .88	Assesses intelligence in the areas of verbal reasoning, quantitative reasoning, abstract /visual reasoning, and short-term memory. Know limitations when administering to children less than 5 years old who are thought to have mild mental retardation or for those persons thought to have severe mental retardation. Form L-M may be recommended in these cases.
Wechsler Preschool and Primary Scale of Intelligence-Revised (WPPSI-R) 1989 The Psychological Coorporation 555 Academic Court San Antonio, TX 78204	3 to 7 years	Information not provided in review	Standard scores, IQ, and functional age of child estimates	Norm Referenced n=1,700 Stratified by: age, sex, geo. reg., ethnic grp, parent occ. & ed. (1986)	Concurent to WPPSI full scale= .87 Performance, Verbal & Composite IQ: IR= .88-.96 TR= .88-.91	Assesses intelligence, with subtests in perceptual motor performance and verbal performance.
Infant Mullen Scales of Early Learning, 1989 T.O.T.A.L. Child, Inc. 244 Deerfield Rd. Cranston, RI 02920	Birth to 42 months	10 to 45 mintues, depending on age	T-Scores, Age Scores	Norm Referenced	Concurrent validity with Bayley= .97, with PLS= .94 to .95. TR and IR =.70 to .99.	Divided into 5 scales: Gross Motor Base, Visual Receptive Organization, Visual Expressive Organization, Language Receptive Organization, and Language Expressive Organization.

[a]Reliability: *(TR)= Test-Retest (SH)= Split-Half (IR)=Inter-Rater
[b]Norm Referenced: Percentile, Percentile Rank, Age Equivalent, Standard Score, Developmental "Age", Quotient (Developmental, Language, etc)
[c]Criterion-Referenced: Mastery levels, Raw score

Selected Cognitive Instruments for Determining Eligibility for Children Birth to 5 Years of Age

INSTRUMENT	AGE RANGE	ADM. TIME	SCORES	TYPE	TECHNICAL DATA (Validity/Reliability)	COMMENTS
Gesell Developmental Schedules Revised, 1987 Developmental Test Materials 17 Fireside Lane Latham, NY 12110	4 weeks to 36 months	45 mintues	Age equivalent level for each domain	Norm Referenced n=927 normal infants from Albany, NY	Predictive validity with Stanford-Binet= .87. IR= .88 to .97	Five domains: Adaptive, gross motor, fine motor, language, and personal-social. The Gesell also includes a parent questionnaire that parallels the test items.
Mulien Scales of Early Learning, 1984 T.O.T.A.L. Child, Inc. 244 Deerfield Rd. Cranston, RI 02920	1.6 to 5.6 years	35 to 45 minutes	T-Scores, Age Scores	Norm Referenced	Concurrent validity with PLS= .77 to .98. TR= .83 to .98 IR= .99	Four scales: Visual Receptive Organization, Visual Expressive Organization, Language Receptive Organization, and Language Expressive Organization.
Differential Ability Scales (DAS) 1990 Psychological Corporation 555 Academic Court San Antonio, TX 78204-2498	2.6 to 17.11 years	25 to 65 minutes	Percentiles, T-Scores, Standard Scores	Norm Referenced n=3,475, stratified	TR= Verbal Ability (VA)= .84 to .89; Non-VA= .79 to .86; GCA= .90 to .94; Correlations with: WPPSI-R: VA with VIQ= .74, NVA with PIQ= .75; K-ABC: GCA with MPC= .75.	Yields composite score called General Conceptual Ability (GCA) and cluster scores (VA) and Nonverbal (NVA)

[a]Reliability: *(TR)= Test-Retest (SH)= Split-Half (IR)=Inter-Rater
[b]Norm Referenced: Percentile, Percentile Rank, Age Equivalent, Standard Score, Developmental "Age", Quotient (Developmental, Language, etc)
[c]Criterion-Referenced: Mastery levels, Raw score

Selected Communication Instruments for Determining Eligibility for Children Birth to 5 Years of Age

INSTRUMENT	AGE RANGE	ADM. TIME	SCORES	TYPE	TECHNICAL DATA (Validity/Reliability)	COMMENTS
Peabody Picture Vocabulary Test (PPVT-R) 1981 American Guidance Service Publisher's Building, Circle Pines, MN 55014 (Spanish version is also available)	2 1/2 to 18 years	10 to 20 minutes	Age equivalent, percentile rank, or stanine	Norm Referenced n=4,200 ages 2.5 to 18 yrs. Stratified by: age, sex, geo. region, occ., ethnic group, comm. size.	Concurrent validity .70 with Stanford-Binet and WISC TR= .77	Test of receptive vocabulary. Requires child to point to a picture that represents the stimulus word presented orally by the examiner. Difficult to establish basal on young children. Read manual carefully.
Sequenced Inventory of Communication Development (SICD) 1984 Western Psychological Services Publishers & Distributors 12031 Wilshire Blvd. Los Angeles, CA 90025	4 months to 4 years	30 to 60 minutes	Age equivalency scores	Norm Referenced n=252 white children at 12 age levels	TR= .90 IR= .90	Assesses receptive and expressive language development. Provides for parent participation and a fifty response language sample. The SICD contains few items for very young children
The Test for Early Language Development (TELD) 1981 Western Psychological Services Publishers & Distributors 12031 Wilshire Blvd. Los Angeles, CA 90025	3 to 8 years	15-20 minutes	Language quotients, Percentiles, and Language ages	Norm Referenced n=1,184 children in 11 states and 1 Canadian Pro. (1979)	.66-.80 with Test of Language Development TR= .90	The TELD measures expressive language and does not measure all abilities necessary for early language development. Additional assessment is needed to support the TELD.
Test for Auditory Comprehension of Language (TACL) 1974 Learning Concepts 2501 North Lamar Austin, TX 78705 (Spanish version is also available)	3 to 6 years	30 minutes	Percentile rank and age equivalency scores	Norm Referenced n=200 on black, Anglo & Hispanic children (no norms for Spanish)	TR= .94 for English version TR= .93 for Spanish version	Measures auditory comprehension of language by assessing skills in grammar, syntax, and morphology (receptive skills). Nonverbal pointing responses are required of the child.

[a]Reliability: *(TR)= Test-Retest (SH)= Split-Half (IR)=Inter-Rater
[b]Norm Referenced: Percentile, Percentile Rank, Age Equivalent, Standard Score, Developmental "Age", Quotient (Developmental, Language, etc)
[c]Criterion-Referenced: Mastery levels, Raw score

Selected Communication Instruments for Determining Eligibility for Children Birth to 5 Years of Age

INSTRUMENT	AGE RANGE	ADM. TIME	SCORES	TYPE	TECHNICAL DATA (Validity/Reliability)	COMMENTS
Preschool Language Scale (PLS-3) 1992 The Psychological Corporation 555 Academic Court San Antonio, TX 78204 (Spanish version available)	1.6 to 6.11 years	20 to 30 minutes	Standard Scores; Percentile Ranks, and Age Equivalents	Norm Referenced	Not available for review	Yields total language, auditory comprehension, and expressive communication scores. Has 3 supplementary assessments: articulation, language sample, and parent questionnaire.
Expressive One-Word Picture Vocabulary Test (EOWPVT) 1979 Academic Therapy Publications 1539 Fourth Street San Rafael, CA 94901	2 to 12 years	5 to 10 minutes	Percentiles and mental age equivalents	Norm Referenced n=1,607 Stratified by: age, sex, and ethnic group	Content valicity correlation with PPVT .29 to .59.	Measures verbal intelligence by means of acquired expressive vocabulary in a picture naming format. Four categories of pictures: general concepts, groupings, abstract concepts and descriptive concepts.
The Nonspeech Test Don Johnston Developmental Equipment Communication & Computer Access PO Box 639 Wauconda, IL 60084-0639	Birth to 48 months (develop-mentally)	4 5 minutes	Age Equivalent scores	Norm Referenced	Not available for review	Can be administered by interview, observation, or direct testing. The test is designed for alternative response modes including communication boards, signing and electronic aids.
Clinical Evaluation of Language Fundamentals-Preschool (CELF-Preschool) 1992 The Psychological Corporation 555 Academic Court San Antonio, TX 78204	3.0 to 6.11 years	30 to 45 minutes	Subtest and composite standard scores, percentile ranks, confidence intervals	Norm Referenced n=800 Stratified by 1980 census data	TR= range .87 to .97 for composite scores IR= 90+% agreement in 1 study with 3 raters Concurrent validity with PLS-3, range .73 to .90	Receptive language score and expressive language score are based on three subtests each. A total language score is based on all six subtests. Optional behavior observation checklist is included.

[a]Reliability: *(TR)= Test-Retest (SH)= Split-Half (IR)=Inter-Rater
[b]Norm Referenced: Percentile, Percentile Rank, Age Equivalent, Standard Score, Developmental "Age", Quotient (Developmental, Language, etc)
[c]Criterion-Referenced: Mastery levels, Raw score

Selected Motor Instruments for Determining Eligibility for Children Birth to 5 Years of Age

INSTRUMENT	AGE RANGE	ADM. TIME	SCORES	TYPE	TECHNICAL DATA (Validity/Reliability)	COMMENTS
Bayley Scales of Infant Development 1969 The Psychological Corporation 555 Academic Court San Antonio, TX 78204	2 months to 30 months	Motor: 20-25 minutes	Raw scores Index Scores (convert to normalized standard scores)	Norm Referenced n=1,262 nor. inf. & child.. Stratified by: geo. area, urb vs rural, sex, race, & ed. of head of house	Correlation of .57 with the Stanford-Binet TR Motor: .68 to .92	Includes mental scales and motor scales. Parent is present during testing. Usually requires a psychologist to administer, or a specially trained professional (see also cognitive).
Developmental Test of Visual-Motor Integration (VMI) (3rd Rev.) 1989 Follet Publishing Company 1010 W. Washington Blvd. Chicago, IL 60607	2 to 8 years	10-15 minutes	Raw scores are converted to age equivalent scores and into scale scores	Norm Referenced	Concurrent validity of the test with CA is .89, with WISC-R is .49 (verbal) and .56 (performance), with Frostig is .72. TR= .83 - Boys TR= .87 - Girls	Child is asked to copy 24 geometic forms (arranged in increasing order of difficulty). Should be administered by a trained professional. To be used in conjunction with fine motor assessment.
Peabody Developmental Motor Scales (PDMS) 1983 DLM One DLM Park Allen, TX 75002	Birth to 83 months	45 to 60 minutes	Standard scores and age equivalency scores	Norm Referenced	Concurrent validity with the Bayley Mental and Psychomotor scales= .78 & .36 TR= .95 Gross motor TR= .80 Fine motor IR= .97 Gross motor IR= .94 Fine motor	Divided into two components: the Gross Motor (reflexes, balance, non-locomotor, locomotor, and receipt and propulsion of objects) and the Fine Motor Scale (grasping, hand use, eye-hand coodination, and manual dexterity).
Test of Gross Motor Development (TGMD) Pro Ed, Inc 8700 Shoal Creek Blvd. Austin, Texas 78758-9965	3 to 10 years	15 minutes	Pass/fail Standard scores, percentiles, Dev. Quotient	Norm Referenced	Complete information in manual	Covers gross motor, locomotor, and object control.

[a]Reliability: *(TR)= Test-Retest (SH)= Split-Half (IR)=Inter-Rater
[b]Norm Referenced: Percentile, Percentile Rank, Age Equivalent, Standard Score, Developmental "Age", Quotient (Developmental, Language, etc)
[c]Criterion-Referenced: Mastery levels, Raw score

Selected Developmental Inventories for Determining Eligibility for Children Birth to 5 Years of Age

INSTRUMENT	AGE RANGE	ADM. TIME	SCORES	TYPE	TECHNICAL DATA (Validity/Reliability)	COMMENTS
Battelle Developmental Inventory (BDI) 1984 DLM Teaching Resources One DLM Park Allen, Texas 75002 (Spanish version available)	Birth to 6 years	45-90 minutes	Percentile Standard Score Age Equivalent	Norm Referenced n=800 Stratified by: geo. region, sex, and race (1981)	Concurrent validity .66 with PPVT-R and .66 with Preschool Language Scale TR= .71 to 1.0	341 items grouped in five domains: Adaptive, Cognitive, Communication, Motor and Personal-Social. Includes adaptation for physical and some sensory impairments.
Learning Accompishment Profile (LAP-D) 1992 Kaplan School Supply Corporation PO Box 609 Lewisville, NC 27023-2014	3 to 6 years		Standard Scores, Z Scores, Percentiles & Age Equivalents	Norm Referenced	Technical data available in separate technical report from publisher.	Assesses four domains, with each having 2 subscales: fine motor, cognitive, language, and gross motor.

[a]Reliability: *(TR)= Test-Retest (SH)= Split-Half (IR)=Inter-Rater
[b]Norm Referenced: Percentile, Percentile Rank, Age Equivalent, Standard Score, Developmental "Age", Quotient (Developmental, Language, etc)
[c]Criterion-Referenced: Mastery levels, Raw score

Selected Assessments for Social, Emotional and Behavioral Development in Determining Eligibility

INSTRUMENT	AGE RANGE	ADM. TIME	SCORES	TYPE	TECHNICAL DATA (Validity/Reliability)	COMMENTS
Child Behavior Checklist Achenbach (CBCL) 1988 University Associates in Psychiatry 1 South Prospect St. Burlington, VT 05401-3456	2 to 3 years	30 to 40 minutes	Standard Scores	Norm Referenced n=273 nonreferred children	Reported in Achenbach et al., J. Abnormal Child Psychology, 1987, 15, 629-50.	Contains 99 problem items. Profile includes 6 syndrome scales, internalizing, externalizing, total problems. Manual and guide are ordered separately.
Child Behavior Checklist Achenbach (CBCL) 1991 University Associates in Psychiatry 1 South Prospect St. Burlington, VT 05401-3456	4 to 8 years	30 to 40 minutes	T-Scores and cutoff for 2 SD	Norm Referenced n=2,368 nonreferred children	Recently updated information in CBCL manual, 1991 profile.	Designed to record in a standardized format the behavioral problems and competencies of children, based on parent report. Manual and guide are ordered separately.
Test of Early Social-Emotional Development (TOESD) 1984 Pro-Ed 8700 Shoal Creek Blvd. Austin, Texas 78758-9965	3 to 8 years	30 to 50 minutes	Standard scores and percentiles	Norm Referenced	Concurrent validity. Correlates well with other behavior measures. TR= .70-.85	Composed of 4 components: student rating scale, teacher rating scale, parent rating scale, and a sociogram.
Social Skills Rating Scale (SSRS) 1990 American Guidance Service, Inc. Publisher's Building Circle Pines, MN 55014-1796	3 to 5 years	20 to 25 minutes	Standard Scales	Norm Referenced	Validity information contained in manual. *Teachers:* TR= .85 social skills TR=. 84 prob. behaviors *Parents:* TR= .87 social skills TR= .65 prob. behaviors	Social skills questionnaire for parents to rate social skills and problem behaviors of their child.

[a]Reliability: *(TR)= Test-Retest (SH)= Split-Half (IR)=Inter-Rater
bNorm Referenced: Percentile, Percentile Rank, Age Equivalent, Standard Score, Developmental "Age", Quotient (Developmental, Language, etc)
[c]Criterion-Referenced: Mastery levels, Raw score

Selected Assessments for Social, Emotional and Behavioral Development in Determining Eligibility

INSTRUMENT	AGE RANGE	ADM. TIME	SCORES	TYPE	TECHNICAL DATA (Validity/Reliability)	COMMENTS
Conners' Parent & Teacher Rating Scales Multi-Health Systems, Inc. 908 Niagara Falls Blvd. N. Nonawanda, NY 14120-2060	3 to 17 years	Each form, 15 to 30 mintues	Standard Scores T-Scores	Norm Referenced	Extensive data provided in manual.	Measures major types of behavioral problems exhibited by a child. Includes a Hyperactivity index that is sensitive to drug effects and correlates with observed behavior.
Scales of Independent Behavior (SIB), 1984 DLM Teaching Resources One DLM Park Allen, TX 75002	3 months to adult	10 to 15 minutes for Early Dev. Scale. 1 hr for total scale	Standard Scores	Norm Referenced n=1,670 Stratified by: race, sex, geo. region, type of community	Detail technical data available in the manual. SH and TR is high (mostly in high .80's or low .90's)	Contains 14 subscales arranged in 4 clusters: Motor skills, Social Interaction and Communication, Personal living, and community living skills. Also has problem behaviors scales with eight categories. Has optional short form for screening.
The Personality Inventory for Children - Revised (PIC-R) 1982 Western Psychological Services Publishers & Distributors 12031 Wilshire Blvd. Los Angeles, CA 90025	3 to 16 years	24 to 90 minutes	Standard Scores	Norm Referenced n=2,390 normal child. from Minn. n=192 child. 3 - 5	Criterion Validity ranges from .62 to .91 for the scales where data were reported. TR= .86	Parent completed rating scale that assesses behavior, affect and cognition. New expanded computer report assists with DSM-III-R diagnosis and educational placement.
Louisville Behavior Checklist Form EI 1984 Western Psychological Services Publishers & Distributors 12031 Wilshire Blvd. Los Angeles, CA 90025	4 to 6 years	25 to 30 minutes		Norm Referenced n=287 children from Kentucky	Author claims content validity based on other derived checklists using similar items. SH= .80 to .907	164 item instrument completed by parent. Samples social and emotional behaviors ranging from social competence to social deviance. To be used as one component of a general clinical evaluation.

[a]Reliability: *(TR)= Test-Retest (SH)= Split-Half (IR)=Inter-Rater
[b]Norm Referenced: Percentile, Percentile Rank, Age Equivalent, Standard Score, Developmental "Age", Quotient (Developmental, Language, etc)
[c]Criterion-Referenced: Mastery levels, Raw score

Selected Assessments for Social, Emotional and Behavioral Development in Determining Eligibility

INSTRUMENT	AGE RANGE	ADM. TIME	SCORES	TYPE	TECHNICAL DATA (Validity/Reliability)	COMMENTS
Kohn Problem Checklist The Psychological Corporation 555 Academic Court San Antonio, TX 78204	3 to 6 years	5 to 10 minutes	Numerical score related to Apathy-Withdrawal or Anger-Defiance	Norm Referenced n=1519 children from NY City Schools & day care programs	Correlation with Schaefer Classroom Behvior Inventory=.78 IR= .77	An inventory of 49 clinically significant negative behaviors, readily observable in the preschool or kindergarten setting.
Kohn Social Comptence Scale The Psychological Corporation 555 Academic Court San Antonio, TX 78204	3 to 6 years	5 to 10 minutes	Numerical score for social competence	Norm Referenced n=1519 children from NY City Schools & day care programs	Correlation with Schaefer Classroom Behvior Inventory=.78 IR= .73	A scale of 73 items designed to measure the degree of competence with which the child masters various aspects of the preschool program.

[a]Reliability: *(TR)= Test-Retest (SH)= Split-Half (IR)=Inter-Rater
[b]Norm Referenced: Percentile, Percentile Rank, Age Equivalent, Standard Score, Developmental "Age", Quotient (Developmental, Language, etc)
[c]Criterion-Referenced: Mastery levels, Raw score

Selected Assessments for Self-Help and Adaptive Development in Determining Eligibility

INSTRUMENT	AGE RANGE	ADM. TIME	SCORES	TYPE	TECHNICAL DATA (Validity/Reliability)	COMMENTS
Vineland Adaptive Behavior Scales 1984 American Guidance Service Publisher's Building Circle Pines, MN 55014	Birth to 18 years	20 to 30 minutes	Standard scores and age equivalents	Norm Referenced n=3,000 Stratified by: sex, race, geo. region, parent ed (1984) Separate norms for MR, SED, and Phys. Hand.	Correlation of .58 between the Vineland and the Adaptive Behavior Inventory and .40 to .70 with the AAMD Adaptive Behavior Scale. SH= .73-.94 in communication, .83-.92 in daily living, .78-.94 in socialization, and .70-.95 in motor skills	Interview format of caregiver to measure adaptive behavior in four domains: communication, daily living skills, socialization, and motor skills. The maladaptive behavior domain can be administered with the Expanded and Survey Forms of the Vineland (starting at 5 years of age).
Scales of Independent Behavior (SIB), 1984 DLM Teaching Resources One DLM Park Allen, TX 75002	3 months to adult	10 to 15 minutes for Early Dev. Scale. 1 hr for total scale	Standard Scores	Norm Referenced n=1,670 Stratified by: race, sex, geo. region, type of community	Detail technical data available in the manual. SH and TR is high (mostly in high .80's or low .90's)	Contains 14 subscales arranged in 4 clusters: Motor skills, Social interaction and Communication, Personal living, and Community living skills. Also has problem behaviors scales with eight categories. Has optional short form for screening.

[a]Reliability: *(TR)= Test-Retest (SH)= Split-Half (IR)=Inter-Rater
[b]Norm Referenced: Percentile, Percentile Rank, Age Equivalent, Standard Score, Developmental "Age", Quotient (Developmental, Language, etc)
[c]Criterion-Referenced: Mastery levels, Raw score

Appendix III

Instruments for IFSP Assessment/Documenting Progress

The following table of instruments for program assessment and documenting progress are recommended for use in Early Intervention and Early Childhood Special Education programs.

Selected Assessments for IFSP Development for Children Birth to 5 Years of Age

INSTRUMENT	AGE RANGE	ADM. TIME	SCORES	TYPE	TECHNICAL DATA (Validity/Reliability)	COMMENTS
Assessment, Evaluation and Programming System (AEPS) 1992 Paul Brookes Publishing PO Box 10624 Baltimore, MD 21285 (Available in August 1992)	DA Range: 1 month to 3 years CA Range: 1 month to 6 years	30 to 60 minutes	% score in relation to the number of items passed: Consist-tent pass, emerging skill, or skill not achieved.	Criterion-Referenced	Concurrent validity with Bayley: Mental age= .93 Motor age= .88 IR= .87 TR= .88 (mean all domains)	Will be published for the first time in August 1992. Two volumes: 1) Measurement, which includes child assessment, family report, and Family Interest Survey; and 2) Curriculum, which is linked to the child assessment.
Assessment, Evaluation and Programming System (AEPS) 1992 Center on Human Development/EIP University of Oregon 901 E. 18th Eugene, OR 97403	DA Range: 3 to 6 years CA Range: 3 to 8 years	30 to 60 minutes	% score in relation to the number of items passed: Consist-tent pass, emerging skill, or skill not achieved.	Criterion Referenced	Concurrent validity with McCarthy: .35 fine motor; .06 gross motor; .66 cognitive; .72 verbal social communication IR= .60-.94 TR= .91 total test	The AEPS for 3 to 6 year olds is available from the University of Oregon. A slightly different format than the Birth to 3 years AEPS contains the child assessment, family report, Family Interest Survey and the Curriculum.
The Callier-Azusa Scale 1978 The University of Texas at Dallas Callier Center for Communication Disorders 1966 Inwood Rd. Dallas, TX 75235	Birth to 9 years	30 to 40 minutes	Age equivalency scores, but authors say to use caution in the interpre-ation.	Criteron Referenced	Content validity only TR= .66 to .97	Administered through observation to children who are deaf-blind and severely handi-capped. Assesses skills and abilities in 5 areas: motor dev-lopment, perceptual abilities, daily living skills, cognition, communication and language, and social development.
Revised Inventory of Early Development, 1991 Curriculum Associates, Inc. 5 Esquire Road North Billerica, MA 01802-2589	Birth to 7 years	Varies	Age equivalents	Criterion Referenced	None reported in manual	Assesses skills in 11 areas; not all areas are administered to a child. Includes social & emo-tional development section and comprehensive skill sequences.

[a]Reliability: *(TR)= Test-Retest (SH)= Split-Half (IR)=Inter-Rater

[b]Norm Referenced: Percentile, Percentile Rank, Age Equivalent, Standard Score, Developmental "Age", Quotient (Developmental, Language, etc)

[c]Criterion-Referenced: Mastery levels, Raw Score

Selected Assessments for IFSP Development for Children Birth to 5 Years of Age

INSTRUMENT	AGE RANGE	ADM. TIME	SCORES	TYPE	TECHNICAL DATA (Validity/Reliability)	COMMENTS
Carolina Curriculum for Infants and Toddlers with Special Needs, 1991 Brookes Publishing PO Box 10624 Baltimore, MD 21285	Birth to 24 months	Varies by age and number of items given	+ or - denotes whether or not a child has achieved a particular skill	Criterion Referenced	None provided	Covers development in cognition, communication, social skills/adaptation, self-help, fine motor, and gross motor. Includes adaptations for children with visual, hearing, andmotor impairments.
Environmental Language Inventory (ELI) 1978 Charles E. Merrill 1300 Alum Creek Drive Columbus, OH 43216	Birth to 6 years	30 to 40 minutes	Frequency, rank order, utterance length, proportion of intelligible words and frequency of unintelligible words.	Norm Referenced n=25, 5 at each age level - Ohio State University	IR= .98	The ELI consists of procedures to assess expressive language in three modes: imitation, play, and conversation. Very limited technical data.
Hawaii Early Learning Profile (HELP) 1979 VORT Corporation PO Box 11132 Palo Alto, CA 94306	Birth to 3 years	Varies by age and number of items given	No specific scores reported, but a developmental chart is provided	Criterion Referenced	None provided for validity or reliability	The HELP charts and HELP Activity Guide provide a month-to-month sequence of normal development in gross motor, fine motor, self help, cognitive, expressive language, and social-emotional development.
I CAN Preprimary and Play Skills HUBBARD PO Box 105 Northbrook, IL 60062	Pre-Primary	Depends on number of items ad-ministered	Pass/fail	Criterion Referenced	None provided in manual	Covers locomotor, object control, control, body control,health/fitness, play equipment, and play participation. Activities accompany each objective.

[a]Reliability: *(TR)= Test-Retest (SH)= Split-Half (IR)=Inter-Rater

[b]Norm Referenced: Percentile, Percentile Rank, Age Equivalent, Standard Score, Developmental "Age", Quotient (Developmental, Language, etc)

[c]Criterion-Referenced: Mastery levels, Raw Score

Selected Assessments for IFSP Development for Children Birth to 5 Years of Age

INSTRUMENT	AGE RANGE	ADM. TIME	SCORES	TYPE	TECHNICAL DATA (Validity/Reliability)	COMMENTS
Oregon Project for Visually Impaired and Blind Preschool Children (ORP)1979 Oregon Project Jackson ESD 101 N Grape St Medford, OR 97501	Birth to 6 years	Not provided	Percentage of critical skills obtained within a particular time	Criterion Referenced	None reported for validity and reliability	Covers development in cognition, language, self-help, socialization, fine and gross motor skills. Emphasis on skills for infants under 36 months including tactile and auditory modes of learning.
Cognitive Observation Guide (COG)1987 Communication Skill Builders PO Box 42050 Tucson, AZ 85733	0 to 24 months	Varies	Descriptive	Criterion Referenced	Field testing required 67% congruence to retain items. IR= .935.	Based on Piagetian Theory. Provides for naturalistic observation of cognitive development during the sensorimotor period.
Learning Accomplishment Profile Revised (LAP-R), 1981 Kaplan School Supply Corporation PO Box 609 Lewisville, NC 27023-0609	30 to 72 months		Age equivalents	Criterion Referenced	None reported	Assesses: gross motor, fine motor, pre-writing, cognitive, self-help, and personal/social. Includes a profile to visually represent the child's development.
Early Learning Accomplishment Profile (E-LAP), 1988 Kaplan School Supply Corporation PO Box 609 Lewisville, NC 27023-0609	0 to 36 months		Age Equivalents	Criterion Referenced		Assesses: gross motor, fine motor, cognitive, self-help, and personal/social. Includes a profile to visually represent the child's development.
Carolina Curriculum for Pre-schoolers with Special Needs, 1990 Paul H. Brookes Publishing Co. PO Box 10624 Baltimore, MD 21285-0624	2 to 5 years	30 minutes to 2 hours	Each item is rated as passed, failed, or emerging	Criterion Referenced		Covers development in Cognition, communication, social adaptation, fine motor, and gross motor.

[a]Reliability: *(TR)= Test-Retest (SH)= Split-Half (IR)=Inter-Rater

[b]Norm Referenced: Percentile, Percentile Rank, Age Equivalent, Standard Score, Developmental "Age", Quotient (Developmental, Language, etc)

[c]Criterion-Referenced: Mastery levels, Raw Score

Selected Assessments for IFSP Development for Children Birth to 5 Years of Age

INSTRUMENT	AGE RANGE	ADM. TIME	SCORES	TYPE	TECHNICAL DATA (Validity/Reliability)	COMMENTS
Erhardt Developmental Prehension Assessment (EDPA) 1982 RAMSCO Publishing CO. PO Box N Laurel, MD 20707	Birth to 15 months	1 hour	Age Equivalency	Criterion Referenced	Lacks documentation on validity. IR= .70.8 and 94.5	A comprehensive neuro-developmental evaluation instrument of prehension. Designed to establish goals for treatment. To be used by, or under the supervision on an occupational therapist.

[a]Reliability: *(TR)= Test-Retest (SH)= Split-Half (IR)=Inter-Rater

[b]Norm Referenced: Percentile, Percentile Rank, Age Equivalent, Standard Score, Developmental "Age", Quotient (Developmental, Language, etc)

[c]Criterion-Referenced: Mastery levels, Raw Score

Selected Assessments for IFSP Development for Children Birth to 5 Years of Age

INSTRUMENT	AGE RANGE	ADM. TIME	SCORES	TYPE	TECHNICAL DATA (Validity/Reliability)	COMMENTS
Burks' Behavior Rating Scale 1977 Western Psychological Services Publishers & Distributors 12031 Wilshire Blvd. Los Angeles, CA 90025	3 to 6 years	20-30 minutes	3 categories on profile sheet: not significant, significant, and very significant	Norm Referenced n=127 preschoolers from 3 S. Cal. Counties	A panel of 26 kindergarten teachers judged the appropriateness of each item	Designed to identify particular behavior problems and patterns of problems. Eighteen scales of behavior are measured. Parent and teacher rate 105 descriptive statements. Observers must be familar with child to give ratings.
Carolina Record of Infant Behavior (CRIB) Carolina Institute for Research on Early Education of the Handicapped, Frank Porter Graham Child Development Center University of North Carolina	Birth to 3 years	10 mintues		Norm Referenced and Criterion Referenced[c]	Information available from research addition	The CRIB is a modification of the Bayley Infant Behavior Record. Assesses basic areas of development in young children.
Joseph Preschool and Primary Self-Concept Screening Test, 1979 Stoelting Publishing Company 1350 South Kostner Avenue Chicago, ILL 60623	3.5 to 9 years	7 minutes	A global self-concept score based on five dimensions is generated	Norm Referenced	Concurrent validity = .66 with Slosson, .69 with YMI	This test contains 15 items which assess self concept. May be used as a screening or diagnostic instrument with preschoolers with disabilities.

[a]Reliability: *(TR)= Test-Retest (SH)= Split-Half (IR)=Inter-Rater

[b]Norm Referenced: Percentile, Percentile Rank, Age Equivalent, Standard Score, Developmental "Age", Quotient (Developmental, Language, etc)

[c]Criterion-Referenced: Mastery levels, Raw Score

Appendix IV

Definitions

The following definitions apply to the section on evaluation and assessment in Early Intervention and Early Childhood Special Education programs.

Definitions

1. **Criterion-referenced assessment**: instruments in which performance is evaluated relative to a predetermined level of mastery of specific skills (the "criterion"). Criterion-referenced tests compare a child's performance on each test item against a standard or criterion that must be met if the child is to receive credit for that item. The child is measured against the criterion rather than against norms established by other children's performance.

2. **Ecological approach to assessment:** the ability to collect accurate information about a child that describes as many aspects of the child's functioning as possible (physical, intellectual, social) in as many settings as possible (home, daycare, preschool, community) so that an intervention program can be developed that will affect as much of the child's life as possible.

3. **Norm-referenced assessment**: instruments that measure mastery of specific skills relative to how children in a reference group perform, usually from various parts of the country and from difference socioeconomic backgrounds. The instruments provide an estimate of the extent to which a child is able to do what the average child his/her age can do. The tabled scores are usually expressed as grade or age equivalents, standard scores, or percentile scores.

4. **Reliability**: refers to the degree to which scores are free from error of measurement, i.e., consistent, dependable, and repeatable. This is usually ascertained by administering the test to the same person more than once and comparing scores (the consistency of test scores over time: test-retest), by administering first the odd items and then the even items on the test to the same person and comparing the two resulting scores (split-half), or by different test-givers administering the test (inter-rater).

5. **Standardized test**: tests that include fixed administration and scoring procedures, empirical testing of items, standard formats, and tables of appropriately derived norms. Standardized tests most often yield a score or set of scores that may be used to compare a child's performance with those of others in his or her age group.

6. **Validity**: the extent to which the test fulfills the purpose for which it is intended. There are three major types of validity:
construct validity - the extent to which the test measures an underlying construct, such as intelligence, self-esteem, or creativity.
content validity - the extent to which test items represent the larger body of content or "domain" the test is intended to measure (Langhorst, 1989).

criterion-related validity - the extent to which a child's performance on an assessment measure can be used to estimate performance on a criterion measure, whether it is future performance (predictive validity) or performance at the same point in time (concurrent validity).

Appendix V

Code of Fair Testing Practices in Education

The following guidelines are adapted from the publication Code of Fair Testing Practices in Education. The complete document is available from the Joint Committee on Testing Practices.

Code of Fair Testing Practices in Education

The **Code of Fair Testing Practices in Education**[1] provides guidelines for professionals involved in educational testing. The Code is meant to be understood by the general public; it is limited to educational tests; and the primary focus is on those issues that affect the proper use of tests. The Code presents standards for educational test developers and users in four areas:

A. Developing/Selecting Tests
B. Interpreting Scores
C. Striving for Fairness
D. Informing Test Takers

The following information summarizes the major points from the Code of Fair Testing Practices in Education, with emphasis only on ***test users.*** For the purposes of Early Intervention and Early Childhood Special Education, the information for test developers is beyond the scope of this technical assistance paper.

A. Developing/Selecting Appropriate Tests

> Test users should select tests that meet the purpose for which they are to be used and that are appropriate for the intended test-taking populations.

Test Users Should:

1. Investigate potentially useful sources of information, in addition to test scores to corroborate the information provided by tests.

2. Read the materials provided by test developers and and avoid using tests for which unclear or incomplete information is provided.

3. Become familiar with how and when the test was developed and tried out.

4. Ascertain whether the test content and norms group(s) or comparison group(s) are appropriate for the intended test takers.

5. Select and use only those tests for which the skills needed to administer the test and interpret scores correctly are available.

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[1] From the Code of Fair Testing Practices in Education. This is not copyrighted material. Copies of the complete Code may be obtained from: Joint Committee on Testing Practices. American Psychological Association. 1200 17th Street, NW, Washington, D.C. 20036.

B. Interpreting Scores

Test users should interpret scores correctly.

Test Users Should:

1. Obtain information about the scale used for reporting scores, the characteristics of any norms or comparison group(s), and the limitations of the scores.

2. Interpret scores taking into account any major differences between the norms or comparison groups and the actual test takers. Also take into account any differences in test administration practices or familiarity with the specific questions (items) in the test.

3. Avoid using tests for purposes not specifically recommended by the test developer unless evidence is obtained to support the intended use.

4. Explain how any passing scores were set and gather evidence to support the appropriateness of the scores.

C. Striving for Fairness

Test users should select tests that have been developed in ways that attempt to make them as fair as possible for test takers of different races, gender, ethnic backgrounds, or handicapping conditions.

Test Users Should:

1. Evaluate the procedures used by test developers to avoid potentially insensitive content or language.

2. When necessary and feasible, use appropriately modified forms of tests or administration procedures for test takers with handicapping conditions. Interpret standard norms with care in the light of the modifications that were made.

Testing Practices. American Psychological Association. 1200 17th Street, NW, Washington, D.C. 20036.

D. Informing Test Takers

Under some circumstances test developers have direct control of tests and test scores. Under other circumstances, test users have such control. Whichever group has direct control of tests and test scores should take the steps described below.

Test Users Should:

1. Provide test takers or their parents/guardians with information about rights test takers may have to obtain copies of tests and completed answer sheets, retake tests, have tests rescored, or cancel scores.

2. Tell test takers or their parents/guardians how long scores will be kept on file and indicate to whom and under what circumstances test scores will or will not be released.

3. Describe the procedures that test takers or their parents/guardians may use to register complaints and have problems resolved.

Appendix VI

Multidisciplinary Team Report - Samples

Multidisciplinary Team (MDT)
Evaluation Report for
Early Intervention

I. Child Information

		Date of Report
Child's Name	Date of Birth	Age
Resident District	Current Program/Services	
Parent/Guardian		
Home Address: Street, City, ZIP		
Home Phone	Work Phone	
Referral Coordinator		Work Phone
Provider (if appropriate)		Work Phone

Reason for Referral:

- ❑ Initial Referral
- ❑ Evaluate Current Program
- ❑ Other (explain):

II. Summary of Evaluations, Parent Input, and Present Performance

Age at which concerns were first noted by parent and/or program:

Developmental, medical, and other significant background information from parent and other sources:

Summary of Evaluation Results: *Include functional performance and other observational data,.* (Add additional pages, as necessary, for this section)

Cognitive:

Receptive Language:

Expressive Language:

Gross Motor:

Fine Motor:

Self-Help:

Social:

III. Determination of Disability:

1. **After examination of the information and substantiating data from individual reports in Section II, does this child meet the criteria for early intervention under OAR 581-15-950?**

   ❑ Yes ❑ No

   If yes, what is/are the areas of developmental delay?

   - ❑ Cognitive development
   - ❑ Receptive language
   - ❑ Expressive language
   - ❑ Gross motor development
   - ❑ Fine motor development
   - ❑ Social, emotional, or behavioral development
   - ❑ Self-help skills, or
   - ❑ From birth through 18 months of age there is documentation from a physician licensed by a state board of medical examiners that the child has an identified genetic, neurological, muscular, or medical condition that will result in developmental delay if not provided early intervention services.

3. **In what specific way does the disability interfere with the child's behavioral and developmental functioning in the present home, preschool, or daycare setting?**

4. **Can all of the child's needs be met within the home, day care, or preschool setting, without specially designed instruction or services?**

   ❑ Yes ❑ No

   If yes, the child does not demonstrate the need for early intervention services that would require placement in an early intervention program.

5. **Do some or all of this child's needs require early intervention services?**

❑ Yes ❑ No

If yes, the need for early intervention services is demonstrated by the evaluation results, observations, medical reports, and parent information.

6. **What learning/teaching styles and program modifications are necessary?**

IV. **Documentation**

1. **Were parents in attendance at the MDT meeting?**

❑ Yes ❑ No

If no, date MDT results shared with parents: _____

MDT Members (Names)	Title	Report Submitted
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No

Other MDT Members	Relationship/Position

2. A dissenting report is filed by an MDT member who does not concur with the MDT findings and report.

Dissenting Reports will be filed by: _____

3. Tentative date of IFSP meeting: _____

Multidisciplinary Team (MDT)
Evaluation Report for
Early Childhood Special Education

I. Child Information

		Date of Report
Child's Name	Date of Birth	Age
Resident District	Current Program/Services	
Parent/Guardian		
Home Address: Street, City, ZIP		
Home Phone	Work Phone	
Referral Coordinator		Work Phone
Provider (if appropriate)		Work Phone

Reason for Referral and Suspected Disability:

- ❑ 3 Year Evaluation
- ❑ Evaluate Current Program
- ❑ Other (explain):

II. Summary of Evaluations, Parent Input, and Present Performance

Age at which concerns were first noted by parent and/or program:

Developmental, medical, and other significant background information from parent and other sources:

Summary of Evaluation Results: *Include functional performance and other observational data.* (Add additional pages, as necessary, for this section)

Cognitive:

Receptive Language:

Expressive Language:

Gross Motor:

Fine Motor:

Self-Help:

Social:

III. **Determination of Disability:**

1. **After examination of the information and substantiating data from individual reports in Section II, does this child meet the criteria for early childhood special education under OAR 581-15-950 or OAR 581-15-051?**

❑ Yes ❑ No

If yes, what are the areas of delay for the noncategorical definition of developmental delay under OAR 581-15-950?

- ❑ Cognitive development
- ❑ Receptive language
- ❑ Expressive language
- ❑ Gross motor development
- ❑ Fine motor development
- ❑ Social, emotional, or behavioral development
- ❑ Self-help skills,

or

If yes, what are the handicapping conditions under OAR 581-15-051?

- ❑ Visual Impairment
- ❑ Hearing Impairment
- ❑ Speech/Language Impairment
- ❑ Orthopedic Impairment
- ❑ Specific Learning Disability
- ❑ Seriously Emotionally Disturbed
- ❑ Mentall Retardation
- ❑ Autism
- ❑ Deaf/Blind
- ❑ Other Health Impairment
- ❑ Traumatic Brain Injury

3. **In what specific way does the disability interfere with the child's behavioral and developmental functioning in the present home, preschool, or daycare setting?**

4. **Can all of the child's needs be met within the home, day care, or preschool setting, without specially designed instruction or services?**

❑ Yes ❑ No

If yes, the child does not demonstrate the need for early childhood special education services that would require placement in an early childhood special education program.

5. **Do some or all of this child's needs require early childhood special education services?**

❑ Yes ❑ No

If yes, the need for early childhood special education services is demonstrated by the evaluation results, observations, medical reports, and parent information.

6. **What learning/teaching styles and program modifications are necessary?**

IV. Documentation

1. **Were parents in attendance at the MDT meeting?**

❑ Yes ❑ No

If no, date MDT results shared with parents: _____

MDT Members (Names)	Title	Report Submitted
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No

Other MDT Members	Relationship/Position

3. A dissenting report is filed by an MDT member who does not concur with the MDT findings and report.

Dissenting Reports will be filed by: _____

5. Tentative date of IFSP meeting: _____

Appendix VII

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